Agency Medical Directors Recommended Priorities for Quality Health Care

A Report to the Governor's Subcabinet on Health

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In support of Governor Locke's Subcabinet on Health,
the Agency Medical Directors (AMD) group will collaborate
across state agencies to identify and assess new opportunities
to improve quality, enhance access and promote
the cost-effective purchase of health care services
in the state's medical care financing and delivery system.

—AMD Mission Statement

Executive Summary

In the summer of 2000, the Governor's Subcabinet on Health charged the medical directors of state health care agencies with evaluating interagency efforts to ensure efficiency and effectiveness in the purchase and regulation of health care services, with a key focus on improving quality. The charge included recommending areas of improvement.

The Agency Medical Directors group (AMD), which comprises the medical directors and senior health policy staff of all executive agencies that either purchase or regulate health care, began meeting in October 2000 to consider how Washington State might address the overarching question: What is government's proper role in improving quality in health care?

The AMD's primary goals were to: (1) identify the very best of the current quality initiatives and where possible build on them; and (2) develop a relatively short list of priority quality goals that could be accomplished in the short-term (within eighteen months of initiation) and within current resources.

After assembling a list of ongoing initiatives and hearing brief summaries of each, the group identified sixteen areas of activity that constituted a conceptual framework for capturing the range of quality improvement activities. AMD assigned a member as a lead to each of the sixteen areas and that lead developed a clear description of his or her area and a one- to two-page white paper describing in greater detail the problem that might be addressed by improving that area.

In October 2001, the AMD scored all sixteen areas across five key dimensions of potential impact:

(1) **Cost savings**—whether improving this area of quality would reduce cost to the state;
(2) **Access**—whether improving this area of quality would improve access for specific sub-populations of the state's citizens;
(3) **Improving Health Outcomes**—whether improvement in this quality area would create better health outcomes, health status, or prevent disability among state citizens;
(4) **Customer Service**—whether improvement in this area would increase satisfaction among patients or other affected persons;
(5) **Provider Burden—**whether improving this area would reduce provider burden**.**

The six areas of activity that emerged from this scoring process as the highest priorities were:

(1) Increase the availability of **clinical preventive services**, particularly for children;
(2) Conduct substantial interagency **demand improvement** activities to assist value-based purchasing;
(3) Develop a substantial interagency **health technology assessment** capability parallel to the interagency pharmacy effort;
(4) Use existing data systems to **track key health outcomes** across agencies;
(5) Assess the effect of the state's 10-year implementation effort using the Resource Based Relative Value Scale (RBRVS) **reimbursement method**, particularly assessing the impact on access and quality of health care;
(6) Improve **disease state management** for targeted conditions, with a particular aim at secondary and tertiary prevention.

For each of these six high-priority areas, small teams of AMD participants developed short-term (within eighteen months) and longer term (more than eighteen months) implementation plans. The full group approved the final drafts of these plans by consensus.

This report provides a summary of each area, including its ranking, a brief description of the problem, possible solutions and desired outcomes, and other aspects, such as timelines and stakeholders.

The AMD believes that this package of quality initiatives, along with the planned implementation of the interagency prescription drug project and Health Insurance Portability and Accountability Act (HIPAA), will substantially improve our capacity to deliver quality health care at improved value. The development of these quality areas can be initiated in the short-term and within current resources. The AMD did not consider efforts aimed at changing the financing system, since this was not within the scope of the AMD charge. Access to quality health care, however, should improve through implementation of these priorities. Specifically, issues related to special populations, consistent with the 2002 Washington State Health Report, will be addressed within each of the six priority areas.

Introduction

The 2002 Institute of Medicine Report *Crossing the Quality Chasm* summarized the critical state of disorganization of the American health care system (see **Appendix 1** for a summary of this report). Among its many recommendations, the report emphasizes the importance of evidence-based practice and the implementation of critical systems to vastly improve coordination of care.

Although various state agencies have undertaken important quality improvement projects (**Table 1** lists the most substantial quality efforts ongoing at this time), the state still faces double-digit medical inflation, reduced access to quality services, and critical health manpower shortages. Structural issues, such as the method of financing the current system, can only be addressed fully by the Legislature. It is incumbent, however, upon the executive agencies in Washington State—which purchase approximately $13 billion of health care per year—to use their substantial buying power to improve the quality of health care services purchased.

It was in this spirit that Governor Locke's Subcabinet on Health charged the Agency Medical Directors group (AMD) in the summer of 2000 with evaluating and recommending ways to improve interagency efforts to promote efficiency and effectiveness in the purchase and regulation of health care services, with a key focus on improving quality.

The group, which comprises medical directors and key senior health policy staff from all executive agencies that either purchase or regulate health care in Washington State, convened on an approximately monthly basis from October 2000 to June 2002. Agencies represented throughout this process included the Department of Health, the Washington State Board of Health, the Department of Labor and Industries, the Health Care Authority (including the Uniform Medical Plan), the Medical Assistance Administration of the Department of Social and Health Services, the Department of Corrections, the Department of Veteran's Affairs, and the Office of the Insurance Commissioner.

The goal of the AMD during this time was to develop a process that would lead to a relatively short list of recommendations of high-priority areas of activity where quality could be improved in the short-term and within current resources. The over-arching question throughout the process was: "What is government's role in improving quality in health care?"

Methodology

The AMD began its work by assembling a comprehensive list of ongoing quality improvement activities across agencies. **Table 1** lists the most substantial quality efforts ongoing at this time. The group heard brief summaries of each of these projects early on so that participants could gain a clearer understanding of the current best work within and across agencies.

The AMD then developed a conceptual framework that organized such projects into sixteen areas of activity, each of which had the potential to lead to quality improvement by increasing inter-agency efficiency or effectiveness. From October 2000 to September 2001, the AMD developed its initial list of sixteen priority quality-of-care issue areas by:

(1) agreeing on the description of each area,
(2) assigning a lead for each area, and
(3) developing a 1-2 page white paper describing the quality issue to be addressed.

The work on each issue area was further informed by the substantial ongoing quality activities within each agency.

In October 2001, the AMD held a structured one-day retreat to:

(1) reduce the sixteen priority areas to a shorter list of high priority issues that could be addressed within 18 months and within current resources; and
(2) begin to develop an outline of a short and long-term action plan to address each of the high priority areas.

The group used a modified Delphi process. Each agency was asked to score all sixteen quality-of-care issue areas across five key dimensions of potential impact:

(1) **Cost savings**—whether improving this area of quality would reduce cost to the state;
(2) **Access**—whether improving this area of quality would improve access for specific sub-populations of the state's citizens;
(3) **Improving Health Outcomes**—whether improvement in this quality area would create better health outcomes, health status, or prevent disability among state citizens;
(4) **Customer Service**—whether improvement in this area would increase satisfaction among patients or other affected persons;
(5) **Provider Burden—**whether improving this area would reduce provider burden.

Other dimensions were also considered, such as *regulatory ease, stakeholder impact, interagency capacity to work together, and the potential longer term need for new resources.* **Table 3** summarizes the average scores across all dimensions for nine key health care programs.

This process produced a prioritized list of the six areas of activity that received the highest scores (see **Table 2** for scores):

(1) Increase the availability of **clinical preventive services**, particularly for children
(2) Conduct substantial interagency **demand improvement** activities to assist value-based purchasing
(3) Develop a substantial interagency **health technology assessment** capability parallel to the interagency pharmacy effort
(4) Use existing data systems to **track key health outcomes** across agencies
(5) Assess the effect of the state's 10-year implementation effort using RBRVS **reimbursement method**, particularly assessing the impact on access and quality of care
(6) Improve **disease state management** for targeted conditions, with a particular aim at secondary and tertiary prevention

During the retreat, teams were assigned to each of the six high-priority areas, and each team developed an outline for short-term (18 or fewer months) and long-term (more than 18 months) implementation. These teams continued working between November 2001 and May 2002 to refine each of the six plans. The AMD approved by consensus the final draft produced by each team. This document reports the results of that process.

External validity of these priority areas became clear with the development of the *2002 Washington State Health Report*. (See **Appendix II.**) The Washington State Board of Health also identified five of the six priority areas identified in the AMD quality improvement effort as being key to the state's success.

In addition, the Community Conversations process, a substantial effort by the Medical Assistance Administration to survey citizens regarding their concerns about access to quality health care, found that most of the quality goals within the priority areas were very consistent with citizen concerns about improving access to quality health care.
The six priority areas on the list are intended to supplement two other critical quality improvement processes already ongoing— the interagency prescription drug project and interagency HIPAA activities.

Several other quality-of-care issues were considered but not prioritized. In the area of administrative simplification, state efforts to assist the private sector with credentialling/re-credentialling have been met with substantial resistance. Other efforts to reduce provider burden that might warrant future consideration include improved targeting of utilization management efforts and reduced paperwork burden. The development of a common definition of medical necessity was also considered in this general area, however, AMD participants felt that efforts to coordinate work in this area were not likely to result in improved outcomes or substantial cost savings to the state.

The AMD believes that this package of quality initiatives, along with the planned implementation of the interagency prescription drug project and HIPAA, will substantially improve our capacity to deliver quality health care at improved value. The development of these quality areas can be initiated in the short-term and within current resources. The AMD did not consider efforts aimed at changing the financing system, since this was not within the scope of the AMD charge. Access to quality health care, however, should improve through implementation of these priorities. Specifically, issues related to special populations, consistent with the 2002 Washington State Health Report, will be addressed within each of the six priority areas.

The body of this report contains brief summaries for short-term and longer term implementation for each of the six priority quality areas. Each summary includes: a brief description of the quality issue; a key question relative to potential solutions; a listing of the work group and lead author; a summary of potential solutions/desired outcome; timelines, particularly those items that could be implemented within 18 months; stakeholder summary; and potential resources required.

Clinical Preventive Services Score: 160

Description: While broad agreement exists about which preventive services should be offered to all children and adults, there is likely underutilization of such services by health plans and providers, and poor understanding of the availability and importance of these services by covered beneficiaries.

Question relative to potential solutions: Are there efficiencies, incentives, or accountability mechanisms available to state agencies that would enhance the availability of these services to the appropriate populations?

Work Group: Maxine Hayes (lead), Alfie Alvarado, Jeff Thompson, Patti Rathbun, Nancy Anderson

Potential Solution/Desired Outcome: There is broad agreement on what services should be offered to children and adults, however there is a lack of understanding in regard to minimum services. There is also a lack of physicians available to provide the minimum services. The AMD recommends that the following actions take place by state agencies. These actions will determine whether there are efficiencies, incentives, and/or mechanisms that will enhance the availability of services to the appropriate populations. The initial focus of this effort will be on children.

(1) Review all preventive measures, such as HEDIS (Health Plan Employer Data & Information Set) vs. Early Periodic Screening, Diagnosis, and Treatment--comprehensive pediatric examination and follow-up mandated in federal Medicaid rules (EPSDT)
(2) Review existing state requirements against other states' experience
(3) Suggest minimum set of clinical preventive services across all payers statewide
(4) Require in contract language for minimal clinical services
(5) Evaluate effects of provision on utilization and outcomes (demonstrate long-term cost effectiveness, e.g., diabetes collaborative).

Timelines/Milestones: Actions 1-3 above could take place in less than eighteen months. Actions 4 and 5 would require a longer time frame.

Stakeholders: Stakeholders for this effort would include state agencies, private organizations, and possible public/private partnerships.

Necessary Resources:

Funding: Funding will not be necessary during the first eighteen months of this project, which will include the assessment of the extent of use of children's clinical preventive services within current state programs. When the project moves into the longer term, dollars will be necessary for staffing and specific analytic expertise.

Expertise: Analytical resources—FTE(s) may be necessary for data analysis.

Data: Data will be collected on an ongoing basis.

Demand Improvement Score: 154

Description: Demand improvement (DI) is a set of behavioral change strategies that alters how consumers and providers of health services respond to indications of injury, illness and disease. DI involves efforts to maintain or improve health status, increase patient satisfaction, or manage disease and/or disability while avoiding, replacing, or reforming the demand for care. Characteristics of demand improvement include:

- Population-based
- Evidence-based medical or behavioral care
- Data driven
- Cost-conscious
- Seeks behavior change
- Reports on outcomes

Demand improvement is often described in the same context as disease state management. The distinguishing characteristic of demand improvement is the *promotion of patient and provider choice* for prevention, early intervention, and self-care. Examples of DI strategies include education on how to pick a health plan or service, suggestions for questions to ask about quality or safety, methods for changing consumer behavior (e.g., in response to direct-to-consumer drug advertising) or redirecting consumer demand. External control strategies *not* generally associated with demand improvement include utilization strategies such as pre-authorization requirements, utilization review, network limitation requirements, preferred provider payment strategies, and mandatory treatment protocols.

Question relative to potential solutions: Are there communications or point-of-service methods that the state could use in the market to help health care consumers choose services with value, proven effectiveness, and positive outcomes?

Work Group: Maggie Baker (lead), Carolyn Coyne, Bob Mootz, Fred Navarro, Don Sloma

Potential Solution/Desired Outcome: The AMD recommends the design and implementation of an interagency pilot project employing demand improvement. A public/private program already in place through the Department of Health—the Antibiotic Resistance (AR) program—is an existing program that could serve as the basis for an interagency pilot project. AR improves quality of care while meeting low resistance from providers and other stakeholders. Use of the AR program as a template would serve two purposes:

(1) Other health-related state agencies could use AR as a demand improvement program
(2) Lessons learned through interagency implementation could be used to assess whether demand improvement programs might be effective in other areas and, if so, suggest process guidelines and outcomes measures.

Specific potential tasks related to this program are:

- Explore and/or implement additional communications strategies that support demand improvement activities. Examples include public affairs sessions, decision support tools, and web-based methods.
- Conduct a survey of existing demand improvement activities with recommendations for future activities.

- Convene a workgroup of interested agencies and/or other groups (e.g., Washington State Medical Association - WSMA) to evaluate and/or choose "best practices".
- Review scientific evidence and recommend preferred drugs, devices, procedures, practices, etc.
- Pilot test the "best practices"—which are most efficient?
- Provide patient and provider education.
- Develop an infrastructure for demand improvement within agencies. If infrastructure is already in place, implement strategies and evaluate outcomes.

Advantages of using the Antibiotic Resistance Program as a basis for an interagency project are:

- Starts with minimal ramp-up time
- Piggybacks onto WSMA's antibiotic project
- Includes multiple stakeholders, such as state agencies and health plans
- Financial resources within existing budgets
- Expertise for conducting a program, although the analytical staff may need to be enhanced
- Low stakeholder resistance

Timelines/Milestones: Work can begin immediately. Program participants would evaluate progress and process during the first eighteen months of pilot phase (1–2 pilots). In the longer term, program participants would implement or test a longer-term project.

Stakeholders: Multiple state agencies, the Washington State Medical Association (WSMA), and statewide health plans would be stakeholders of this proposed program. Public/private partnerships, including partnerships with drug companies, may enhance the effectiveness of the program.

Necessary Resources:

Funding: Funding will not be necessary during the first eighteen months of this project, which will include the assessment of agency capacity to initiate new communication strategies relevant to demand improvement. When the project moves into the longer term, dollars will be necessary for staffing and specific analytic expertise.

Expertise: May need analytical staff to augment program

Data: Data necessary to conduct this program already exists.
Data would also be collected prospectively at time points during, and possibly, after the project.

Communication: Existing communication methods within agencies could be used to disseminate information to Washington residents, state agencies, and providers. Communication methods include the Internet, provider bulletins, provider training, and public forums.

Political Support: The Antibiotic Resistance program would be relevant to and benefit a large population. The political risk should be low. This particular effort would not be perceived by the public as a cost-reduction strategy, but rather as a program to improve quality of care.

Health Technology Assessment Score: 146

Description: We all face the issue of how to access the best available data to make coverage or medical necessity decisions. The main issues are (1) what evidence of efficacy and safety exist to allow such decisions to be made and (2) what is the most efficient way to gather the evidence.

Question relative to potential solutions: Could there be a more systematic or centralized method for determining the best available evidence regarding efficacy/value of an emerging or existing new technology (e.g., devices, off-label drug uses, durable medical equipment, procedures)? Are there opportunities for partnering with health professional organizations (e.g., the Washington State Medical Association) to rebuild a technology assessment (TA) capacity in the state? Are there opportunities here for developing guidelines with health professional organizations?

Work Group: Gary Franklin (lead), Lee Glass, Bless Mamerto, Jeff Thompson, Grace Wang

Potential Solution/Desired Outcome: The only feasible solution in the area of technology assessment is creation of an interagency technology assessment capability. This interagency group would accomplish the following:

- Define emerging and existing technologies
- Decide whether technology assessment should be
    - developed centrally or exist piecemeal among agencies using state resources
    - purchased through contracts with companies, such as ECRI (formerly the Emergency Care Research Institute)
    - developed and purchased
- Develop common protocols, methods and procedures
    - to prioritize existing technologies currently covered at all agencies
    - to prioritize available research (FDA, company, and community data)
    - to review outcomes, i.e., what are safety issues for devices? Engineering capacity? Efficacy?
    - to analyze cost effectiveness
    - to determine feasibility of tracking technologies
- Link evidence development with state providers, WSMA, and Chiropractic Advisory Committee (CAC). Obtain a common understanding of the linking process.
- Determine whether community standards of care exist. Partner with existing groups that already work in this arena.
- Determine whether coverage decisions are made at the interagency level; obtain an Attorney General (AG) opinion in this regard
- Look at purchaser versus insurer perspectives

Timelines/Milestones: In the short-term (less than eighteen months), an interagency technology assessment team could review existing methods of assessment currently in use at various agencies. An AG opinion could be obtained as to whether coverage decisions could be made at an interagency level. A white paper would be created to outline potential savings and safety in the area of technology assessment.

Long-term (more than eighteen months), a standard interagency assessment process would be created. This process would be used by state purchasing agencies when evaluating new and existing technology.

Stakeholders: All state agencies, WSMA, CAC.

Necessary Resources:

Funding: Funding will not be necessary during the first eighteen months of this project, which will include the assessment of agency ability to develop common technology assessment protocols. When the project moves into the longer term, dollars will be necessary for staffing and specific analytic expertise.

Expertise: Analytical resources—FTE(s) may be necessary for data analysis.

Data: Data will be collected on an ongoing basis.

Communication: The interagency technology assessment team would develop a broad method of disseminating information statewide.

Tracking Health Outcomes Score: 146

Description: The data currently collected in a variety of health information systems of state and federal agencies and health plans could be used to track health outcomes and monitor performance measures. To date, there has not been sufficient dialogue across state agencies to agree on what conditions or behaviors (e.g., diabetes, asthma, depression, tobacco use, substance abuse and obesity) are the most important to track. Also, there are few organized efforts to systematically mine existing databases toward this end.

Question relative to potential solutions: Are there systematic ways to use *current* data systems and resources to track health outcomes and apply the findings to enhance quality of care? What policy changes and/or future resources are needed to strengthen the ability of state agencies to track health outcomes and apply findings?

Work Group: Beth Anderson (lead), Gary Franklin, Bill Hagens, Linda Murphy, Patti Rathbun, and Mary Uyeda

Potential Solution/Desired Outcome: The AMD recommends using data in existing health information systems to track health outcomes, monitor performance measures, (e.g., for screening and prevention services as well as for treatment) and apply the findings. The following issues would need to be addressed:

- Identify target issues (e.g. morbidity, mortality, and sentinel events) and the methodology and criteria to prioritize them.
- Agree on desirable quality outcomes/practices and identify the indicators and common data elements needed to monitor those outcomes/practices for the targeted issues.
- Identify which indicators and data elements are already available as part of existing databases (e.g., comprehensive hospital adverse reporting system - CHARS) or systems that will be developed (e.g., HIPAA- driven systems).
- Develop a tracking process for key target issues.
- Identify and disseminate best practices statewide, e.g., through guideline development.
- Use public/private partnerships to the greatest extent possible, particularly in regard to best practices.

After the December 2000 release of DOH's *Medication Errors Report and Recommendations*, DOH and the Foundation for Health Care Quality convened key stakeholders (e.g. WSMA, Washington State Hospital Association, Washington State Nurses Association) to prioritize the report's recommendations. They determined the focus should be on best practices. Since HCA and the Foundation were in the early phases of developing a patient safety conference related to HCA's work with Leapfrog, it was agreed to include best practices. Recognizing the need to work more closely with patients and plans, DOH, HCA, the foundation and other organizations are taking steps to start a Patient Safety Coalition. This includes:

- Addressing issues/concerns about the confidentiality of information identifying patients, providers or plans. Amending the Coordinated Quality Improvement Programs statute (RCW 43.70.510) to protect data shared across organizations.
- Addressing other barriers to sharing information.
- Developing a variety of ways to communicate findings on health outcomes and on subjects like medication errors to consumers and practitioners. (e.g., Web sites, brochures, articles for publication in newspapers, and newsletters)

Additional steps to support this process are:

- Use agency practices and influence to recognize and reward quality practices, including improving outcomes and error reduction. This is already being done as part of the Leapfrog Programs.
- Develop interagency consumer awareness programs.
- Use public/private partnerships to the greatest extent possible, particularly in regard to best practices.

Timelines/Milestones:

Less than eighteen months:

- Identify agency expertise.
- Identify outcomes to track based on criteria that develop (e.g. reasonably prevalent conditions; high potential for adverse outcomes).
- Identify and, within current resources, begin tracking outcomes and sentinel events, such as morbidity, mortality, infection and post-surgical re-hospitalization from existing governmental and health plan databases.
- Do gap analysis to identify policy changes and/or resources needed to track additional outcomes.
- Develop a consumer agenda.
- Define guidelines.

More than eighteen months:

- Use gap analysis results to make changes, secure additional resources necessary to track additional outcomes.
- Address needed legislative changes.
- Develop plan for interagency tracking capacity.
- Propose cross agency contract language on data reporting from plans.
- Develop interagency tracking capability.
- Develop and implement a pilot program to address one or more target issues.

Stakeholders: Stakeholders include state agencies, providers, public/private partnerships and consumer groups.

Necessary Resources:

Funding: Funding will not be necessary during the first eighteen months of this project, which will include the assessment of our current tracking capability. When the project moves into the longer term, dollars will be necessary for staffing and specific analytic expertise.

Expertise: Analytical resources—FTE(s) may be necessary for modifying data systems as needed and for data analysis.

Data: Data will be collected on an ongoing basis.

Communication: Data collected will be available to consumers, providers, legislators, health plans and agencies.

Political Support: Information made available on health outcomes would be relevant to and benefit a large population. The political risk should be low. This particular effort would not be perceived by the public as a cost reduction strategy, but rather as a program to improve quality of care.

Reimbursement Methods Score: 142

Description: Since 1992, federal government payers have used a resource-based methodology (as opposed to a market-based approach) to establish relative value scales for all clinical procedures that have a CPT code. Three state agencies (MAA, L&I, and HCA) have worked together within the Technical Advisory Group (TAG) to bring providers and stakeholders into consensus on reimbursement issues and rates. Concerns have developed within health care communities in Washington State that the methods used for setting values for specific procedure codes may have negatively impacted access, quality of care, and the health care labor market. In addition, providers in Washington have become increasingly organized and strategic in negotiating state contracts, including promoting antitrust legislation to permit exemptions for collective provider negotiations. Since statewide adoption of the resource-based approach in the mid-'90s, there has not been any formal study of the impact of reimbursement levels on access or quality in Washington State. Several studies in other regions have reported variable outcomes depending on region, population, etc.

Question relative to Potential Solutions: What has been the federal impact of RBRVS reimbursement methods on access, health labor availability, and the viability of private and academic health institutions?

Work Group: Jeff Thompson (lead), Beth Anderson, Lee Glass, Bill Hagens, Bob Mootz, Linda Murphy, and Don Sloma

Potential Solution/Desired Outcome: The AMD recommends a broad approach to study issues related to reimbursement levels. Necessary actions are as follows:

- A workgroup with involvement from interested agencies should be established to inventory specific reimbursement issues and information that would be needed to determine if and how reimbursement rates are impacting access and quality in Washington State. A key work product of such a group should include an overview of the scope of work and a comprehensive review of available literature. In addition, this study should conduct an accounting of existing Washington State specific data, listing of information deficits, and an analysis of reimbursement affects in Washington.

- A systematic review of current studies should be conducted of the relationships reimbursement rates have on access and care quality. Such a review should consider the scientific quality of the research, the populations studied, and regions included.

- Delineate which issues remain unresolved. (This may best be accomplished by contract.)

- Attention should also be given to the relationships of reimbursement rates and practices to the provision of an appropriate mix of health care services (e.g., adequate preventive care, incentives for services with high value, higher efficiencies and effectiveness, levels of evidence-based medicine, such as behavioral health interventions, substance abuse treatment, medical and medication compliance, diet, and exercise).

- Based on the results of a comprehensive, systematic review and stakeholder feedback, specific recommendations should be made regarding the need to conduct pilot projects that add potential value to Washington reimbursement methods.

- Identify opportunities for administrative simplification for providers (e.g., standardized billing, documentation and reporting requirements for reimbursement).

Timelines/Milestones:
Less than eighteen months:

- Document the scope of work needed to determine what relationships are known between reimbursement and access/quality, including information currently available and what is needed for Washington State specifically.
- Conduct a systematic review of existing research on relationships between reimbursement and access/care quality. Review should lead to recommendations on what studies and data is needed in Washington State to determine linkages and track trends.
- Determine opportunities for input into the federal CPT and RBRVS process.
- Work through the TAG/RSC process to compile a list of priorities from various stakeholders for assessment of reimbursement methods.

More than eighteen months:

- Develop a strategy to provide input into reimbursement methodologies that increase the value, quality, effectiveness, and access to members in Washington State.

Stakeholders: Stakeholders for this process include the Legislature, the Governor, WSMA and other appropriate provider trade associations, RSC/TAG, and the Governor's Subcabinet on Health.

Necessary Resources:

Funding: Specific contract dollars may be required during the first 18 months to conduct the systematic review. When the project moves into the longer term, dollars will be necessary for staffing and specific analytic expertise.

Expertise: Analytical resources—FTE(s) may be necessary for data analysis. Affected agencies may need to commit staff time to coordinate, review, and participate in the process.

Data: Data will be collected on an ongoing basis. Data may be collected in-house and via an outside contractor.

Political Support:

1. Project has the potential to address provider issues and concerns related to reimbursement methodology, and address any relationship to access or quality (e.g., provider exodus).
2. The issue of value-based purchasing, contracting for the maximal quality at a reasonable price, is gaining increased congressional attention and seems likely to become a higher profile issue for federal payers within the next few years.
3. Administrative simplification, a major area of concern for the Washington provider community, may result from more standardized reimbursement methodologies.

Disease State Management Score: 140

Description: Disease State Management programs have developed in response to the widespread disorganization and lack of evidence-based care for people with more complex and sometimes progressive disorders, particularly those likely to last for long periods of time (e.g., diabetes). Disease Management programs can enhance provider capacity to render cost-effective care, improve client function, and minimize future disability by:

- Facilitating provider adherence to nationally recognized guidelines for treatment where appropriate and;
- Coordinating evaluation and referral for multiple client service needs where chronic conditions are complicated by co morbidity and social vulnerability.

Question relative to potential solutions: Are there systematic, cost-effective methods for improving the delivery of care to persons with more complex or chronic health conditions, particularly methods likely to reduce or prevent impairment and disability?

Work Group: Nancy Anderson (lead), Alfie Alvarado, Fred Navarro, Don Sloma

Potential Solution/Desired Outcome: The AMD will determine, after further discussion and consideration, its goals in regard to Disease State Management. To arrive at that point, the following steps should be taken:

- Define and describe our definition of Disease State Management. Focus on single or related multiple chronic conditions. Include multi-disciplinary and multi-institutional models (e.g., Ed Wagner's chronic care model).
- Establish the basic information of interest, including but not limited to, presence of responsible clinical provider, use of guidelines where applicable, coordination of services, costs, utilization, and outcomes.
- Review L&I's OHS project that targets specific conditions.
- Review and consider potential savings associated with drug/alcohol treatment for all clients of state-funded health care, as documented for high-cost Medicaid clients in the SSI Cost Offset Pilot Project.
- Review evaluation components of MAA Disease Management Program as they become available, including cost, client satisfaction, provider satisfaction, and utilization/outcome indicators.
- Review ongoing and newly identified state initiatives that focus on clients who receive services from multiple agencies and/or are high-cost service utilizers.
- Attend August 2002 National Governors' Association Policy Academy on Chronic Disease Prevention and Management.

Timelines/Milestones: All actions outlined above could be completed within eighteen months.

Stakeholders: Stakeholders for this priority include clients, advocates, providers, professional organizations, condition-specific organizations (e.g. American Lung Association of Washington), Legislature, health plans, and state agencies. Private funders may become stakeholders in the implementation and/or evaluation of disease management initiatives in the future.

Necessary Resources:

Funding: Funding will not be necessary during the first eighteen months of this project, which will include the assessment of ongoing disease management pilot projects. When the project moves into the longer term, dollars will be necessary for staffing and specific analytic expertise.

Expertise: Resource needs have been included in existing disease management initiatives (professional, program, and analytic expertise). Therefore, no new resources are necessary, but public-private partnerships would enhance capacity.

Data: Data will be collected on an ongoing basis.

Communication: Information about these initiatives can be communicated to stakeholders through traditional means (reports, community meetings, representation at provider associations, etc). It may also be possible to include state Web-based communication resources.

Political Support: The Legislature and Governor have indicated considerable support for the cost-effective management of state clients with chronic conditions. MAA's disease management pilot was developed under legislative mandate. The Legislature also sought to implement a consolidated state-purchased prescription drug program, which included implementation of up to five disease management programs for persons covered through state purchased health care programs. Although this program was not enacted during this session, it is likely that the Legislature will include these pilots in its strategies to control costs for the 2003-2005 biennium.

Conclusions

The priority quality areas developed by the AMD were identified through a systematic group process and a semi-quantitative prioritization method. Each of the six areas could be initiated within a relatively short time frame (eighteen months or less), and within current resources. The development of the six priority areas would be complementary to other ongoing quality projects (**Table 1**) and to two other critical inter-agency efforts that are already being implemented— the interagency prescription drug project and the interagency HIPAA project.

It is important to note that during the time of development of these priority areas by the AMD, the Washington State Board of Health published its 2002 Washington State Health Report, which includes five of the six priority areas developed by the AMD (**Appendix 2**). In addition, external validity of the process was apparent through the systematic collection of citizen opinion through the Community Conversations project conducted by the Medical Assistance Administration. The values related to health care delivery, expressed by the state's citizens, were parallel to the six priority areas developed by the AMD, including an emphasis on:

(1) a focus on prevention in children;
(2) the use of proven technologies to simplify processes;
(3) the provision of more seamless and integrated services;
(4) better management of resources; and
(5) partnering with communities to ensure accessibility and accountability.

Of note, administrative simplification, related to reducing provider burden, received quite a bit of discussion and evaluation but was not highly prioritized as a stand-alone quality area. The main area of discussion related to credentialling/re-credentialling; however, the private sector has been resistant to substantial government involvement in this activity. Areas that may be riper for important burden reduction include improved targeting of utilization management programs and reduced paperwork. Further simplification by developing a more consistent and standard definition of medical necessity was also considered, but the group believed this would be too difficult to implement among both private and public payers. It also felt that even if this could be accomplished, it might not have substantial value in improving quality or reducing burden.

The AMD believe the efforts and resources applied to these six priority areas would result in substantially improved quality, access, and reductions in administrative overhead and costs. These priority areas can be developed within existing resources. As they mature, agencies, policy makers, public/private partnerships, grants, or request legislation may come forward for consideration by the Subcabinet on Health.

Table 1

INTERAGENCY MEDICAL DIRECTORS
ONGOING QUALITY ACTIVITIES
Summary of selected current quality initiatives:

Multiple Agencies
Inter-agency Prescription Drug Project;
TEAMonitor (A multi-agency group (DOH, DSHS, HCA and MAA) dedicated to ensuring high quality health care for the state's managed care enrollees)**;**
Technical Assistance Group (TAG), including DLI, HCA, and MAA;
Standards for Health Services – DOH & DOC

Board of Health
Minimum set of clinical preventive services

Public/Private Initiatives
Antibiotic Resistance Program
All-Plan Medical Director Meetings

Department of Health
Credentialing; Medical errors; WA State Diabetes Collaborative

Department of Labor & Industries
Occupational Health Services Pilot

Health Care Authority
Clinical Outcomes Assessment Program (COAP); Leapfrog

Medical Assistance Administration
Provider review; Disease State Management; Therapeutic Consultation Service

Table 2
AMD PRIORITIZATION OF QUALITY ISSUES (May 3, 2002)

QUALITY OF CARE ISSUES AND VALUE MEASURE	For: Cost, Access, Health Outcomes, Customer Service & Provider Burden	
	Score	***Ranking***
1. Clinical preventative services	**160**	**1**
2. Demand Improvement	**154**	**2**
3. Health Technology Assessment	**146**	**3**
4. Tracking Health Outcomes	**146**	**3**
5. Reimbursement Methods	**142**	**4**
6. Disease State Management	**140**	**5**

Table 3
AMD PRIORITIZATION MATRIX
Agency Scores and Ranks
October 5, 2001

QUALITY OF CARE ISSUES AND VALUE MEASURE	For: Cost, Access, Health Outcomes, Customer Service & Provider Burden		For: All Dimensions with Regulatory Ease		For: All Dimensions without Regulatory Ease	
	Score	*Ranking*	*Score*	*Ranking*	*Score*	*Ranking*
1. Medical Errors: Significant reduction of errors, patient safety	**134**	**6**	**224**	**7**	**206**	**8**
2. **HIPAA:** Data issues, confidentiality, privacy	**120**	**9**	**211**	**11**	**195**	**11**
3. Drug and Device Costs: Increased reimbursement	**127**	**8**	**217**	**10**	**200**	**9**
4. Health Outcomes: Tracking and measurement	**134**	**6**	**223**	**8**	**206**	**8**
5. Flow of Information: Credentialing/ Decredentialing	**114**	**11**	**211**	**11**	**199**	**10**
6. Disciplinary Activities: Accountability, billing issues	**112**	**12**	**205**	**13**	**182**	**13**
7. Utilization Management: Value purchasing	**128**	**7**	**236**	**6**	**208**	**7**
8. Technology Assessment: Efficacy/value of new tech.	**146**	**3**	**243**	**5**	**226**	**3**
9. Special Access Needs: Efficiencies, special populations	**117**	**10**	**220**	**9**	**196**	**10**
10. Reimbursement Methods: RBRVS, DRGs, ACGs	**142**	**4**	**246**	**4**	**215**	**6**
11. Disease State Management: Coordinated care, cost-effective	**140**	**5**	**255**	**3**	**223**	**4**
12. Demand Improvement: Point of service, standardize	**154**	**2**	**264**	**2**	**231**	**2**
13. Self-referral/Financial Conflict of Interest: Improved methods	**96**	**14**	**187**	**14**	**167**	**14**
14. Min. Set—Clinical preventative services: Availability	**160**	**1**	**280**	**1**	**248**	**1**
15. Data system/Technology Enhancement: Improve system	**146**	**3**	**246**	**4**	**220**	**5**
16. Medical Necessity: Definition	**108**	**13**	**206**	**12**	**187**	**12**

Appendix 1

Summary of Report:

Crossing the Quality Chasm: A New Health System for the 21st Century (March 1, 2001), Institute of Medicine

Appendix 2

2002 Washington State Health Report